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ABSTRACT

Mental health services for children and adolescents from the states' perspective is the topic of this document. The introduction provides statistics on mental health service needs and utilization in this population, while highlighting underserved needs. The history of mental health services provision and funding is traced from isolated state hospitals, to community programs, to coordination of service systems, and finally, because of restricted financing, back to traditional residential care. It is noted that states are responsible for over 90% of expenditures. The lack of service coordination is presented. Barriers to appropriate service delivery are discussed including economic disincentives and crises orientation. General legislative guidelines for state legislatures to follow in establishing a continuum of care for children are given for the areas of prevention, non-residential, and residential services. Specific state legislation is summarized. Future trends and implications are discussed. The major implication is that children with emotional disorders who do not receive treatment grow up to be disabled adults. A five-page case study of Kentucky is presented. Ten references are listed. (ABL)

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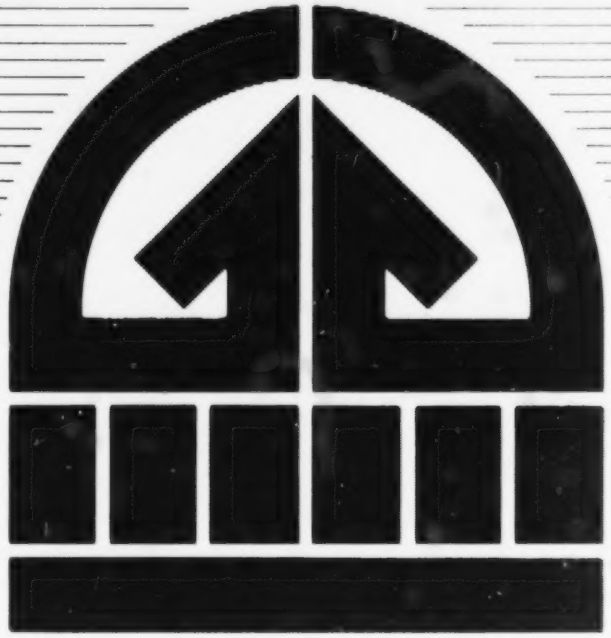

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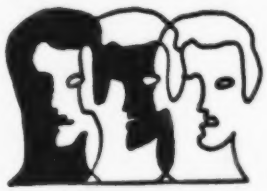
MENTAL HEALTH SERVICES FOR CHILDREN AND YOUTH:

STRENGTHENING THE PROMISE OF THE FUTURE

by

Rebecca T. Craig



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MENTAL HEALTH SERVICES FOR CHILDREN AND YOUTH: STRENGTHENING THE PROMISE OF THE FUTURE

INTRODUCTION

- Judy has been experiencing difficulties in school for several years. Now 12, she is generally depressed and maintains poor relationships with her peers. After hitting a school teacher a year ago, Judy has been in and out of residential placements and psychiatric hospitals. The system has alternately overprotected and rejected her.

- Ross, a 14 year old boy, has been picked up by the police for possession of a controlled substance and for breaking and entering. At school he is disruptive and frequently acts out. Although he has received inpatient care on several occasions, Ross always returns to an abusive home environment without any case management or follow-up services.

- Melissa was diagnosed as being severely emotionally disturbed three months ago. Although her father's insurance will pay for some treatment, the closest facility is 200 miles away and covered treatment is limited to 90 days.

According to Jane Knitzer, author of Unclaimed Children (1, p. ix), of the three million seriously disturbed children in this country, two-thirds are not receiving the services they need, while untold others receive inappropriate care. Furthermore, the most disturbed children may often be the least likely to get help. These children are "unclaimed" by the public agencies with the responsibility to serve them.

Together, the stories of children like Judy, Ross and Melissa add up to a major public health crisis, the gravity of which is illustrated by the following statistics, compiled by the National Institute of Mental Health and by the Institute of Medicine:

- 99,850 children and adolescents, 17 years of age or under, underwent psychiatric hospitalization in state, county and private mental hospitals and in non-federal general hospitals during 1980 (2).

- An additional 350,000 received outpatient services in psychiatric clinics during 1975 (3) and evidence indicates that this number has increased in recent years.

- 86 percent of children and youth receiving treatment in residential facilities for substance abuse were reported to have some degree of concurrent emotional disturbance or behavior disorder (2).

- The suicide rate for youth, 15 to 24 years of age, has increased from five in 100,000 in 1961 to 13 in 100,000 in 1983--a 150 percent increase (4, p. 5).

- The National Institute of Alcohol Abuse and Alcoholism estimates that three million of our youth are problem drinkers. Of the 25,000 to 28,000 traffic fatalities in this country each year, at least 10,000 are young Americans between the ages of 15 and 24 (5, p.2).

- Mental disorders and addictions rank third in personal health expenditures, one major indicator of social costs (4, p. 5).

HISTORICAL PERSPECTIVE: THE IMPACT OF FEDERAL AND STATE INITIATIVES

Federal and state governments, in addition to many national organizations, have recognized the critical need to improve systems of care for children and adolescents and to find new ways to generate funds and support for these programs. However, the federal response to the needs of seriously emotionally disturbed children seems to be diminishing in the face of budget constraints.

From pre-World War II days through the 1960s, mental health care was primarily confined to large isolated state hospitals with few resources and support systems in the community. Realizing the inadequacy of this situation, the U.S. Congress passed the Community Mental Health and Mental Retardation Centers Construction Act in 1963 to provide incentive for developing community programs. However, it was not until 1972 that mental health programs were required to deliver specialized services to children with mental health problems. The resulting programs were often determined primarily by the funding sources and eligibility criteria and little attention was paid to overlap and gaps in service.

The late 1970s and early 1980s brought about a changed focus in the area of children and youth services. With the passage of the Education for All Handicapped Children Act in 1975 and the Adoption Assistance and Welfare Act of 1980, the federal government authorized assistance in providing support for special education and child welfare needs. While these acts do not deal directly with mental health services for children, they do address the multiple needs of children and the coordination of service systems. States also began to take tentative steps in developing a system of care for children and adolescents and mental health departments began to reflect a policy focus on children.

Between 1981 and 1983, the U.S. experienced an economic recession which forced states to find the means to raise taxes and reduce spending. Increased Medicaid costs and the required local contribution began growing disproportionately to local revenues. The effect was to cause many states to relieve local governments of this "fiscal burden" by assuming the cost for certain programs, leaving fewer dollars for less restrictive children and youth mental health services. The federal government was likewise affected and federal support for children and youth mental health services was reduced by 8 percent and continues to decline (6, p. 10).

Reimbursement systems and the economic climate have served as "fiscal disincentives" to continued development of community-based programs at the local level for mentally ill children and youth as well as other disabled groups. These factors have also reinforced communities' inclination to place more mentally ill youth in unnecessarily restrictive settings outside the community. Subsequently, a disproportionate share of future funding expenditures on traditional state residential care was spurred at the expense of community-based care. As of 1983, two-thirds of all expenses go for either inpatient care (63 percent) or residential services (4 percent) while the remaining one-third is used for ambulatory and treatment services (6, p. 16).

The primary responsibility for financing mental health services to children has been assumed by state governments, with an estimated $1.06 billion spent nationally in 1983 (6, p. 1). Additionally, many states obtain financing for child and adolescent mental health programming under Title XIX of the Social Security Act via Medicaid and through grants to states for funding of a wide range of mental health efforts under Title XX. Nevertheless, federal funding responsibility for all federally supported programs for children is well under 10 percent of total expenditures (7, p. 9).

A recent attempt to focus attention on children's mental health problems was made in 1984, when Congress mandated the Child and Adolescent Service System Program (CASSP). One and a half million dollars was targeted to develop a new initiative to improve service delivery and ensure a comprehensive, coordinated system of care. CASSP provides grant support to state mental health agencies or to the state children's agency that has primary responsibility for children's mental health services. Through this type of initiative, the federal government can serve as a catalyst in the development of children's mental health services, while the major responsibility for providing mental health services remains with the states.

SYSTEM OF CARE: CONFUSION, GAPS AND BARRIERS

The reality of mental health programming for children and adolescents historically has been one of disorganization, lack of coordination and an overemphasis on unnecessarily restrictive treatment programs. Not only the mental health system, including vocational rehabilitation, substance abuse and mental retardation programs, but also other key agencies, such as education, health, child welfare and juvenile justice, are involved in the delivery system for children and youth. The concept of interrelatedness becomes obvious as do the possibilities for agency turf battles and coordination problems. Additionally, there has been a sizable gap between what is known about effective practices for serving emotionally disturbed children and use of that knowledge.

Since currently 50-80 percent of those children and adolescents who have been identified as chronically mentally ill do retain their disability into adult life, the lack of appropriate treatment and services for this population is having a tremendous impact on future costs of mental illness to the public.

In comparing existing mental health services for children and youth, and in studying the results of research on program effectiveness, Dr. Robert Friedman of the Florida Mental Health Institute, identified the following problem areas which present barriers in delivering appropriate services to children (8, pp.16-32):

- Definitional Ambiguity. Diagnosing mentally ill children and adolescents is generally determined by the process of "clinical judgment," often characterized by a lack of clarity in the separation of those youth with a chronic mental illness from those with other developmental disabilities.

- Lack of Options in Models of Service Delivery. The concept of a "continuum of care" revolves around the need for a wide range of available services to encompass the corresponding wide range of needs. In the absence of such a continuum of care, children tend to

end up in more restrictive settings than might be otherwise warranted.

- Diffuse Accountability for Services. In spite of mandates for the educational system to assume responsibility for education and related services to handicapped children, "under-identification" of these youth remains a problem. A "pass the buck" syndrome is also common, wherein the child is passed back and forth within the various systems, with each system declining responsibility.

- Use of Inappropriate Treatment Models and Techniques. Mental health treatment for children has been modeled after adult treatment techniques, which do not work well with seriously disturbed children.

- Service Fragmentation. Children and youth with serious and complex problems receive services in an uncoordinated and piecemeal fashion, if at all.

- Service Barriers. Due to funding, age and other requirements, eligibility and service provision criteria often interfere with providing early intervention, continued care and appropriate services.

- Absence of Trained Professionals. Most teachers, psychologists, psychiatrists, social workers and other professionals have little if any specialized training in working with emotionally disturbed children.

- Economic Disincentives. Over two-thirds of state mental health agency funds go for residential care. Day treatment is not usually reimbursable with federal dollars. Third party payments tend to cover only certain services for limited periods. Because of these disincentives, restrictive and inappropriate services are relied upon.

- Crises Orientation. Most funding and planning for mental health programs have been short-term and oriented towards the "crises of the moment." Planning for future needs, early intervention and community-based programming is urgently needed.

- Lack of Advocacy. Although some states have begun to focus on children and youth issues, far too many states lack a state-level focus and the needed interest and leadership to advocate effectively for the mental health of children.

GENERAL LEGISLATIVE GUIDELINES

To respond to the varied and often complex needs of emotionally disturbed children, states should consider establishing a continuum of care for children's mental health services. The continuum of care model for children should include three components (8, pp. 8-14):

- Prevention Services. These services attempt to reduce the incidence of emotional problems in children through promoting positive mental health, attempting to modify the impact of systems or institutions that affect an individual's mental health, and educating the public about mental illness. Early intervention is particularly important in working with youth.

- Non-Residential Services. This broad category generally involves diagnosis and evaluation, outpatient treatment and crises counseling, and day treatment.

- Residential Services. This component is made up of therapeutic foster care, therapeutic group homes, residential treatment centers and inpatient programs. State hospital programs for children serve as the final back-up when other alternatives prove unsuccessful.

States should also acknowledge the problems encountered by children within the mental health system and attempt to improve service delivery. Dr. Friedman, Florida Mental Health Institute, has developed a variety of general principles upon which children's mental health services should be planned and delivered (8, pp. 5-8).

The continuum of services should be multi-system, involving all available agencies in planning and working together on behalf of these youth.

Services for mentally ill children and adolescents should be provided in the least restrictive setting possible. Many studies have shown that there is a tendency to overestimate the amount of restriction actually needed.

Services for emotionally disturbed youth should be family-based. The family must be closely involved in the treatment process for it to work effectively. Studies indicate that for those adolescents successful in reentering the community, the majority came from homes with at least one natural parent while the majority of reinstitutionalized adolescents were in custody of a human service agency.

Careful, thorough planning needs to be done both on the state and local levels, with the emphasis being on each community's resources, needs, priorities and weaknesses.

Services for mentally ill youth should be community based. Studies indicate that the major factors in determining the long-term outcome for residential clients are not related to the type and severity of psychopathology but to the post-discharge resources available to the youth.

Service delivery systems need to strike a better balance between prevention and early intervention programs versus more expensive, restrictive residential services programs.

Treatment should be provided in a manner that is accessible to the client; it should be timely and of sufficient intensity. Intensive outreach programs are often the most effective means of treatment and frequently help avert hospitalization.

Education is the key to early intervention. Most experts agree that money spent today in good prevention programming, saves in treatment costs later on. Especially important are programs for children of alcholics as it is standard for these youth to exhibit subsequent problems.

Fiscal incentives must be provided for community systems. It has been consistently demonstrated that community-based systems of services are more effective, more cost-efficient and more humane. It would behoove federal and

state programs to reflect this knowledge in a concrete manner by funding more community-based programs.

THE STATES' RESPONSE IN RECENT YEARS

Increased recognition of the problems facing mentally ill children and adolescents, as well as an expanded emphasis on resolving these problems, has produced a ground swell of legislation in this area. Summaries of legislation outlined below were largely excerpted from State Legislation Affecting the Delivery of Mental Health Services to Children and Youth (9).

Comprehensive Service Efforts. At least eight states, Connecticut (Conn. Gen. Stat. § 17.410 - 17.447), Delaware (Vol. 64 Del. Laws, Chap. 108, 1983), Hawaii (1974 Hawaii Sess. Laws, Act 210), Michigan (1984 Mich. Pub. Acts, Act 186), New Hampshire (1983 N.H. Laws, Chap 416), Rhode Island (1979 R.I. Pub. Laws, Chap. 248) and Washington (1983 Wash. Laws, Chap. 192) have taken definitive legislative steps towards addressing the mental health needs of minors, either through consolidating service delivery efforts or through mandating a comprehensive service delivery system. Michigan (1984 Mich. Pub Acts, Act 186) created a new section of the Michigan Code focusing on services to emotionally disturbed children and youth, establishing a single port of entry/exit system, and authorizing the development of children's diagnostic and treatment services within the community mental health centers. During the 1986 session, South Carolina (H.B. 3524, pending) will consider a bill to create a continuum of care for emotionally disturbed children.

At least 13 additional states initially took or are in the process of taking preliminary steps toward a comprehensive service delivery system for minors. To begin with, at least 10 states have established study commissions or committees, including Delaware, Georgia, Maine, Maryland, Massachusetts, Missouri, Nebraska, New Jersey, Virginia and Washington. Maine (1983 Me. Laws, Chap. 47) established a commission to examine the availability, quality and delivery of services to children with special needs. Missouri (Mo. Rev. Stat. § 210.102, 1984) established the Children's Services Commission to encourage greater interagency coordination, more effective utilization of existing resources and less duplication of efforts.

Secondly, at least three states, California (1982 Cal. Stats., Chap. 32), Georgia (1978 Ga. Laws, p. 193) and Maine (Me. Rev. Stat. Ann., § 22.1051) have mandated the development of comprehensive plans for service delivery. California's law additionally required the Department of Mental Health to evaluate and report to the legislature on the existing delivery of services to emotionally disturbed children and the development of a plan for a comprehensive service system.

Furthermore, at least three states, California (1984 Cal. Stats., Chap. 1474), Oregon (1967 Or. Laws, Chap. 455) and South Carolina (1983 S.C. Acts, Act 151) have initiated pilot projects. South Carolina established the South Carolina Continuum of Care Project for Emotionally Disturbed Children. The California legislation established the demonstration project for developing and implementing a model children's comprehensive mental health service system and legislation is pending this year to continue the program.

Service Needs and Components of Care. At least 23 states have considered or passed legislation addressing distinct needs or populations relative to

mental health care for children and youth. To begin with, at least nine states have addressed the need for residential programs. For example, Arizona (1979 Ariz. Sess. Laws, Chap. 210) provides for joint responsibility between school districts and state agencies for the residential placement and treatment of emotionally disturbed children. Other states which have moved in this area include Indiana, Louisiana, Maine, Maryland, New York, North Carolina, Oklahoma and Washington.

At least five states, California, Connecticut, Florida, Hawaii and Maine have considered or passed legislation targeting certain groups within the larger group of children and youth in need of mental health services. Hawaii (1984 Sess., House Resolution 395) required a study on the feasibility of establishing intermediate nursing facilities for the care of severely multiple-handicapped children. Maine (1982 Me. Laws, Chap. 307) developed a statewide coordinated delivery system for preschool handicapped children. If passed, New York (A.B. 5688) would establish an aging out services demonstration program for children for whom existing adult services are not appropriate. Colorado (Colo. Rev. Stat. § 122.1.110, 1985) requires that a program on the dangers of substance use/abuse be taught in grades K-12.

At least three states, Illinois (1983 Ill. Laws, P.A. 699), Oregon (1983 Or. Laws, Chap 731) and Texas (1981 Tx. Gen. Laws, Chap. 572) have established early intervention programs. Texas established an Interagency Council on Early Intervention Services, charged with developing and implementing a state plan for early childhood intervention services, as well as an Early Childhood Intervention Program, charged with coordinating efforts between various state agencies involved in identifying developmentally delayed children. If passed, New York (A.B. 2828) would establish school-based early intervention detection and prevention programs to aid in preventing childhood emotional disorders.

During the 1986 session, at least four states, Arizona, Massachusetts, Oklahoma and Tennessee have introduced or continued legislation concerned with the voluntary or involuntary commitment of minors. Moreover, Oregon (Or. Laws, Chap. 525) is one state that recently authorized a minor to receive outpatient care without parental consent.

Funding. At least 10 states, Arizona, California, Florida, Maine, Minnesota, Nevada, New Mexico, New York, Oregon and Wyoming, have considered or passed legislation that addresses itself to paying for or specifically providing services to children and youth. New York (1984 N.Y. Laws, Chap. 305) authorized grants to nonprofit organizations to cover the costs incurred in developing residential facilities for children and youth. Wyoming (Wyo. Stat. § 21.13.315, (1983)) established a mechanism for state payment of residential and educational costs of court-ordered placements of children in private facilities or group homes. During the 1986 session, at least four states, Maine, Maryland, New York and Oklahoma considered legislation which would affect funding mechanisms of mental health services for children and youth.

FUTURE TRENDS AND IMPLICATIONS

Although children's mental health services have improved dramatically in the past 15 years, these systems continue to have major gaps and barriers. Even with the significant growth of non-residential alternatives, children are

still unnecessarily confined, primarily due to a lack of available or appropriate alternatives to inpatient care. There has been a tremendous growth in mainstream education of children with emotional or mental problems, but the average state only serves two-thirds of the special education needs (6, p. 6). Involvement of the family in the treatment process remains minimal despite the evidence that suggests a high percentage of mentally ill children are from multi-problem families. Early intervention and prevention programs, perhaps the most effective and efficient mental health services, are overburdened and usually the first to be defunded when financial crises arise. And finally, there remain countless children with severe emotional problems who are not obtaining the services they so desperately need.

While the federal government has played a more active role in children's mental health during the recent years, continued support is vulnerable in light of the current fiscal situation. A majority of the Reagan Administration's proposed spending cuts over the next three years promise to come at the expense of programs administered by state and local governments (6, p. 9). Service delivery programs to children are likely to be seriously affected. It will become increasingly important for states to make every effort to make the most efficient use of available resources.

State legislatures and other governmental bodies, foundations and other private sector institutions, and mental health systems are attempting to produce positive changes, despite the current fiscal crises, in the delivery of mental health services to children and youth. A swell of legislation within the states during recent years clearly indicates increased attention to children and efforts to improve the system. Private foundations, such as the Edna McConnell Clark Foundation, have joined forces with policymaking organizations, such as the National Conference of State Legislatures and the National Governor's Association, to improve services through policy and programmatic decisions. Innovative programs, such as the Homebuilder's program which provides crises intervention in the home, are combining creative measures to produce successful and cost-effective treatment of emotionally disturbed children and their families.

Most are agreed, however, that much remains to be done. Children's mental health is a pay now or pay later problem. The problems of children with emotional disorders, for the most part, get worse without treatment. Those unserved as children grow up to be disabled adults, requiring extensive and expensive care. To stem this relentless and ever-growing need for mental health services among children and adults, policymakers and providers should focus on:

- Developing a continuum of care to address the changing and varied mental health needs of children and their families;
- Coordinating and integrating the delivery system so that those children and families in need can easily access the system;
- Involving families in the treatment process and attempting to maintain children in their own home.

CASE STUDY: KENTUCKY

INTRODUCTION

A minimum of 21,655 children in Kentucky--2 percent of the child population--have severe emotional problems. During the 1984-85 fiscal year, Kentucky's community mental health centers served the following numbers of clients under age 18:

- 432 drug abuse clients;
- 635 alcohol abuse clients; and
- 12,811 mental health clients.

It is estimated that as many as half the school age clients seen at any one time by mental health centers have serious long-term problems. Nearly all of these clients require multi-agency involvement and coordination.

Although severely limited by resources, Kentucky has expressed both legislative and executive concern throughout the past year for this disabled population of children.

- In March 1985, the Governor's Protective Services Advisory Committee recommended landmark changes in the state's protective service system. A special legislative session in July 1985 appropriated $8.3 million in new funds to carry out the committee's recommendations.

- In September 1985, The Institute of Children issued a report concerning services for emotionally disturbed children which summarized problems and recommendations for treating disturbed children in Kentucky.

- The Governor's Task Force on Drug and Alcohol Abuse Prevention submitted a report in December 1985 that addressed the impact of substance abuse on Kentucky's children and made recommendations.

- In March 1986, the Kentucky General Assembly consolidated into a unified Juvenile Code for persons under 18 all statutes concerning interstate compact, protective services, status offenders, juvenile public offenders, youthful offenders, termination of parental rights and mental health commitments. The code will become effective July 1, 1987, along with an initial annual appropriation of $7.5 million.

To address specifically Kentucky's issues and concerns regarding mental health and substance abuse care for children and youth, the NCSL Mental Health Project agreed to provide the state with a technical assistance program in October, 1985. Dr. Robert Friedman, Director of the Research and Training Center for Improved Services for Emotionally Disturbed Children at the Florida Mental Health Institute, provided information on mental health services for children. H. Leonard Boche, Executive Director of the Minnesota Association of Treatment Programs, offered information on many substance abuse issues among children. Much of the information contained in this case study was provided by the Legislative Research Commission, the Departments of Social Services and Mental Health and Mental Retardation Services, the Institute for Children and the Governor's Task Force on Drug and Alcohol Abuse Prevention.

The suggestions presented are not necessarily those of the NCSL Mental Health Project and the National Institute of Mental Health.

PROBLEMS FACING THE MENTALLY ILL CHILDREN OF KENTUCKY

Kentucky is facing a variety of problems which affect the available resources and the delivery systems for mentally ill children. These difficulties have left a number of individuals without services or with inappropriate or limited services. The main problems, documented by the state departments concerned with services to children and youth and their families, include the following: limited funds, lack of state-level policy focus on children and mental health/substance abuse problems, lack of coordination among systems and increasing placement demands and resource needs.

Limited Funds and Increased Resource Needs. Kentucky has depended heavily upon federal money to provide community-based, non-residential mental health and substance abuse services to children and their families. As a result, the major reduction in these funds that occurred during the early 1980s was a critical loss for which the state could not compensate. If Kentucky is forced to absorb even more reductions in federal support, it would be impossible, without major new state allocations, to close the service delivery gaps or create needed resources.

The Kentucky system, including the Department of Social Services (DSS) and the Department of Mental Health and Mental Retardation Services (DMHMRS), serves an increasing number of children and youth in need of treatment resources. Some children and youth remain in residential treatment programs longer than necessary because suitable community placements cannot be found. Kentucky's children with multiple handicaps are the most inadequately served. Community mental health centers and other social service programs have severely limited capacities to perform outreach with special populations and to provide services to rural areas. The increased demand for services has placed severe constraints upon the existing mental health and substance abuse service system.

Lack of State-Level Policy Focus on Children and Mental Health/Substance Abuse Problems. For many years Kentucky has not had a visable unit at the state level responsible for non-residential community mental health services to children. This lack of state-level staff solely responsible for and knowledgeable about children's mental health and substance abuse issues has resulted in a lack of state leadership in the areas of advocacy, planning, funding, training and effective implementation of community-based, non-residential services to children and their families.

Lack of Collaboration Among Systems Which Provide Mental Health and Substance Abuse Services to Children/Youth and Their Families. Children with mental health problems in Kentucky often require a range of services from a variety of agencies, including community mental health centers, the Department of Social Services, schools, courts, hospitals and detention centers. Due to a historical lack of coordination among these agencies, these children have often been served in an uncoordinated and fragmented fashion. Also, where gaps have existed between and among service providers, some children have not been served.

SOLUTIONS TO COMBAT PROBLEMS FACING MENTALLY ILL CHILDREN IN KENTUCKY

Financing Care and Developing Resources. Within the past several months, Kentucky has increased the amount of federal and state money targeted for community mental health services to children and youth and their families.

- In July 1985, the Department of Mental Health and Mental Retardation Services (DMHMRS) received a Children and Adolescent Service System Program (CASSP) grant from the National Institute of Mental Health (NIMH) to improve mental health services to children and youth with emotional problems.

- The DMHMRS is allocating more state money for community-based, non-residential mental health services to children and youth and their families. Through the reorganization of the department, seven state-funded personnel are now devoted to children's mental health. Additionally, the DMHMRS has implemented the first Request for Proposal which focuses solely on mental health services to children and youth. These funds will be used to help support demonstration projects designed to create and enhance community-based, non-residential mental health services to children and youth.

- The Department of Social Services (DSS) Children's Residential Services has expanded programming and services through the following: contracts with two mental health centers to provide two homes for emotionally disturbed children; a pilot program of family treatment homes, being implemented throughout the Division of Field Services; and regular staff training related to sexual abuse and alcohol and drug abuse.

Both DSS and DMHMRS are experiencing an increase in the number of children and youth needing services for emotional disturbance or substance abuse and in the severity of their problems. As a result, Kentucky must obtain additional financial support and develop additional treatment resources.

- To protect investments of primary treatment, the system for substance abuse and mental health should develop a continuum of care including home-based intervention, comprehensive case management services, day treatment and residential aftercare.

- School-based prevention planning should involve the development of school personnel training, coordination with other involved service providers, and increased programming, including student assistance plans, support groups and peer counseling.

- Necessary funds should be provided for the treatment of indigent persons and Medicaid eligible clients in need of treatment for chemical dependency.

- Programs need to be developed to serve children with multiple handicaps and outreach expanded to special populations.

In addition, Kentucky could produce revenue for increased financial support of substance abuse and mental health prevention, intervention and treatment programs through specific measures.

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- Raising the Alcohol Premimum Tax on wholesale beer and wine by 10 cents per gallon. Such a tax increase would provide approximately $10 million.

- Levying a surcharge on all alcohol and drug related fines for all persons convicted of drug and alcohol offenses. A $25-$50 surcharge could provide approximately $1 million-$3 million.

- Contracting with outside agencies for as many direct services as possible. Such outside contracting might prove more cost effective than the state providing services directly.

- Creating and implementing incentives for less restrictive treatment settings since community-based services are generally considered more cost effective.

- Encouraging interagency collaboration to share resources and minimize service replication.

State Level Focus on Children and Mental Health/Substance Abuse Problems. Establishment of the Children's Branch within the DMHMRS and the implementation of the CASSP within Kentucky has increased the visibility of and the priority given to children's mental health services at the state and local levels. This will result in an increase in all activities pertaining to children's mental health services.

State-level funding and planning efforts on behalf of children and youth also have increased.

- The Children's Branch is currently conducting a statewide needs assessment to better define the characteristics and the service needs of children and youth with emotional problems. The findings of this effort will be incorporated into a state mental health plan for children. This plan will address needs, will identify an ideal continuum of care, and will outline a strategy with policy and funding recommendations to meet identified needs.

- Kentucky's CASSP has plans to fund and provide a variety of educational conferences and workshops around the state for policy-makers, service providers and families of children with emotional problems.

- Increased state-level staff can now provide advocacy, planning, training and technical assistance. With the availability of these resources, efforts will be made to encourage utilization of more effective treatment modalities with emotionally disturbed children.

Increased Collaboration Among Systems Providing Mental Health and Substance Abuse Services to Children/Youth and Their Families. With the assistance of CASSP, the Children's Branch is presently involved in a number of activities to increase the collaboration among systems which serve children and youth with emotional problems.

- The Children's Branch has organized an interagency advisory council to assist in developing a state mental health plan for children.

- DMHMRS is requesting that funding priority be given to those agencies which are attempting to increase the availability of coordinated interagency services to children and youth and their families with emotional problems.

During the upcoming years, Kentucky could consider a variety of executive and legislative measures to improve the coordination of services to children who are emotionally disturbed.

- Formal coordination between the Department of Education and the Department of Mental Health and Mental Retardation Services and the Department of Social Services should be implemented to ensure the best programming for consultation, training, prevention and treatment resources for children.

- Interagency councils and citizens advisory boards could be established to coordinate services among state government agencies and other agencies and programs serving emotionally disturbed children.

- Training, education and other support services could be provided to community task forces to achieve successful solutions at a community level for problems that are encountered by children.

- Coordination strategies for the case management of children with multi-agency needs and strategies could be used to encourage and support each community mental health center in its efforts with community agencies and individuals.

CONCLUSION

Scarce resources are largely responsible for many of the problems encountered by Kentucky's mental health agencies charged with serving children and youth. The most obvious manifestation of this lack of resources has been the existence of major gaps in the necessary mental health and substance abuse continuum, especially with regard to community-based treatment options. However, Kentucky is making significant progress in increasing its commitment of resources to emotionally disturbed children and promoting more efficient and effective use of the services which are available through greater interagency collaboration.

Failure to provide adequate treatment for children and adolescents will produce tremendous human and economic consequences for the individual, the family and the community. State legislatures have a critical role in shaping every aspect of the children and youth delivery system. The foresight, planning and actions of each state legislature will determine the future course of services and programming for mentally ill children.

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TECHNICAL ASSISTANCE PROGRAM TAPES AND BACKGROUND MATERIALS

Available through the NCSL Mental Health Project are edited tapes of the actual technical assistance program presented for Kentucky in October 1985, as well as the background materials distributed at the Kentucky program.

The tapes of Kentucky's technical assistance program, entitled "Mental Health Services for Children and Youth" features Betsy Burke, California Office of Child and Youth Services, Dr. Robert Friedman, Research and Training Center for Improved Services for Seriously Emotionally Disturbed Children at the Florida Mental Health Institute, and H. Leonard Boche, Minnesota Association of Treatment Programs. The speakers addressed the mental health and substance abuse problems confronting children and offered suggestions for addressing these problems in Kentucky.

Background materials relating to mental health services for children and youth include a summary of select state legislation, a discussion of model programs, a bibliography and a checklist that interested legislators and staff may return for copies of legislation and bibliographic materials.

If you wish to receive loan copies of these tapes, or the background information distributed at the technical assistance program, please copy, complete and return the form below to the Mental Health Project, NCSL, 1050 17th Street, Suite 2100, Denver, CO 80265.

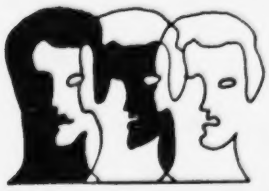
Name: _____

Title: _____

Address: _____

_____

Requesting Kentucky background materials ____ tapes ____



MENTAL HEALTH PROJECT

PROJECT OVERVIEW

In February 1985, the National Institute of Mental Health (NIMH), U. S. Department of Health and Human Services, awarded a contract to the National Conference of State Legislatures (NCSL) to conduct technical assistance programs for state legislators on mental health policy issues.

The goal of the NCSL's Mental Health Project is to improve the decision-making ability of state legislators on mental health policy by providing specific assistance to chosen states and disseminating information surrounding mental health issues.

Through this fourteen month program, the Mental Health Project can respond to specific issue and format needs of legislators. By involving the Panel of Experts, a group composed of legislators and persons with mental health experience, expert consultants, and state policy makers, programs will be developed to provide a variety of services to states, including testimony, special workshops and seminars, and staff assistance.

Based upon input from the state legislatures, ten states were chosen to receive technical assistance with state-specific mental health issues. Along with the programs, background materials, audio tapes, and a State Legislative Report will be developed for each issue area and are available free of charge to requesting parties. The scheduled technical assistance programs include:

South Carolina	Involuntary Civil Commitment	May 10, 1985
California	Mentally Ill Homeless	August 7, 1985
Missouri	Mental Health Services Coordination	September 24, 1985
Kentucky	Mental Health Services for Adolescents	October 3-4, 1985
Pennsylvania	Revolving Door Syndrome of Mental Health Services	October 23, 1985
Virginia	Housing for the Mentally Ill	November 18, 1985
Oklahoma	Community Care for the Chronically Mentally Ill	December 4-5, 1985
New Hampshire	Mandated Mental Health Insurance/ Mental Health Services for the Elderly	January 9, 1986
Michigan	Mentally Ill Offender	January 28, 1986
Oregon	Mental Health Services Funding	March 4, 1986

The Mental Health Project Manager is Rebecca T. Craig, who may be contacted at NCSL's Denver office (303) 623-7800. The federal project officer is Lee Dixon, Office of Policy Development, Planning, and Evaluation, National Institute of Mental Health, at (301) 443-3175.